

Primary Care in a New Era: Disillusion and Dissolution?

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The current dilemmas in primary care stem from 1) the unintended consequences of forces thought to promote primary care and 2) the “disruptive technologies of care” that attack the very function and concept of primary care itself. This paper suggests that these forces, in combination with “tiering” in the health insurance market, could lead to the dissolution of primary care as a single concept, to be replaced by alignment of clinicians by economic niche. Evidence already exists in the marketplace for both tiering of health insurance benefits and corresponding practice changes within primary care. In the future, primary care for the top tier will cater to the affluent as “full-service brokers” and will be delivered by a wide variety of clinicians. The middle tier will continue to grapple with tensions created by patient demand and bureaucratic

systems but will remain most closely aligned to primary care as a concept. The lower tier will become increasingly concerned with community health and social justice. Each primary care specialty will adapt in a unique way to a tiered world, with general internal medicine facing the most challenges. Given this forecast for the future, those concerned about primary care should focus less on workforce issues and more on macro health care financing and organization issues (such as Medicare reform); appropriate training models; and the development of a conception of primary care that emphasizes values and ethos, not just function.

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For decades, health policy experts have bemoaned the beleaguered status of primary care. Rather than building our health care system based on “provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing sustained partnerships with patients, and practicing in the context of family and community,” (1) our health care system continues to emphasize technologically oriented specialty care.

Although this contrast is unremarkable, given the long-standing pro-specialty biases in our medical payment and education systems (2, 3), what is perhaps more surprising is that primary care seems more precarious than ever, even as forces thought to promote it continue to strengthen. Managed care, with its emphasis on cost-effective care for populations, was envisioned by many as a major stimulus to promote primary care. Medical school curricula have evolved to place greater emphasis on early exposures to patients, longitudinal clinical experiences, and clinical clerkships with community-based physicians, all of which are thought to increase interest in primary care.

Yet, primary care residency matches were down 3.8% in 2001, the fourth straight year of decline (4). Graduating medical students’ interest in generalism declined from 40% in 1997 to 32% in 2000 (5) (Figure 1 [6]). Primary care physicians feel beleaguered, and evidence of a primary care “backlash” is emerging among students and medical school faculty.

In fact, the current dilemmas in primary care stem from the unintended consequences of forces thought to promote primary care and the “disruptive technologies of care” that attack the very concept of primary care itself. These forces, in combination with “tiering” in the health insurance market, could lead to the dissolution of primary care as a single concept, to be replaced by alignment of clinicians by economic niche, not role.

THE ASSAULT ON PRIMARY CARE

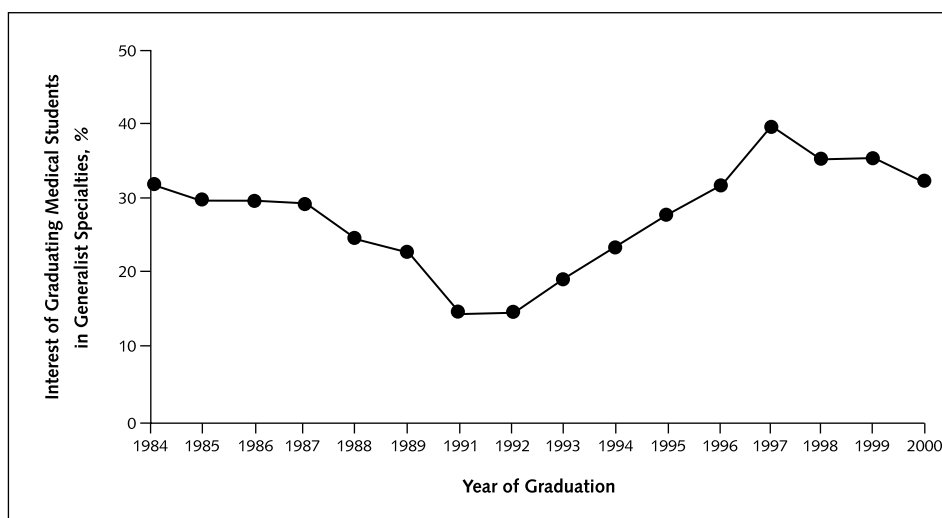
Ironically, primary care is being assaulted by forces that had been thought to be friendly to it—managed care and medical education reform. The growth of managed care, particularly capitation, would, the theory went, create new incentives for primary care by increasing income, status, and reputation and by promoting comprehensive and cost-effective care. Under capitation, primary care clinicians would reap real financial rewards for providing continuous, comprehensive, high-quality care by reducing unneeded procedures, hospitalizations, and specialty services. Medical education reform, with an emphasis on early patient care experiences and curriculum changes beyond biomedical science, would also promote primary care (7).

In reality, although managed care dominated the market, payment policy perpetuated a discounted fee-for-service financing system. Few physicians could actually manage care under capitation financing, and the managed care marketplace evolved such that most health maintenance organizations (HMOs) paid physicians discounted fee-for-service rates, as did preferred provider organizations (PPOs). As a result, in 1999, the average physician derived only 17% of revenues from capitation (8). Thus, neither enhanced income nor incentives for cost-effective care came to pass as a result of managed care. The technology-intensive biases of fee-for-service payment continue to penalize physicians with less resort to technology (Figure 2) (9).

Nonetheless, consumer and clinician anger over “gatekeeper” arrangements and highly publicized limitations on care in HMOs created a managed care backlash, within which primary care was swept up. Consumers equated “quality” with “choice” and began to frame primary care as a barrier to quality, not as an enhancer.

Moreover, managed care promoted “disruptive technologies” in primary care, creating new challenges. As described by Christensen, Bohmer, and Kenagy in their

Figure 1. Interest in generalist specialties among graduating medical students between 1984 and 2000.



Specialty certification data are not available for 1990. Data obtained from reference 6.

widely cited Harvard Business Review paper, “Will Disruptive Innovations Cure Health Care?” (10), “disruptive” innovation in a field occurs from below when less expensive approaches enable a product or service to be delivered faster, better, or cheaper. Managed care promoted the growth of nurse practitioner and physician assistant programs, both to enhance the productivity of physician practice and to offer a more cost-effective form of primary care itself. From 1992 to 1997, this group of health professionals doubled, and further growth is anticipated (Figure 3) (7, 11).

Managed care also created the need for hospitals and medical groups to become more efficient in inpatient care, giving rise to the hospitalist movement (12, 13). Although the debate on the virtues of hospitalists continues, the hospitalist movement clearly created an “alternative pathway” for internists interested in a broad practice that crosses subspecialty boundaries. By 1999, 65% of internists had hospitalists in their communities (14), and the hospitalist movement is projected to grow significantly (15, 16).

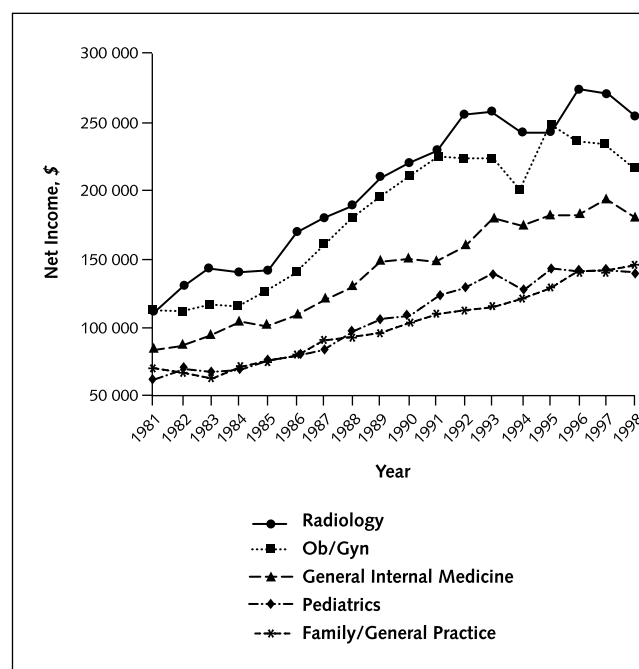
Most devastating, the policy promise that primary care could increase quality and reduce health care costs was not supported by evidence. Some studies noted that primary care clinicians were not regularly superior in the delivery of secondary preventive services (17), and research continued to show that—not surprisingly—specialists are more current in their practices than are primary care physicians (18, 19). Managed care’s use of discounts and the health insurance underwriting cycle succeeded in moderating health care costs in the mid-to-late 1990s—an important object lesson, suggesting that market forces independent of primary care can attack cost inflation (20, 21).

Primary care fared scarcely better within the walls of academe. Although many medical schools revised their overt curricula to create a greater balance between general-

ism and specialism, the “hidden” curriculum that serves powerfully to socialize learners continued to promote subspecialty training and tertiary care. The population-based approaches of the best managed care organizations, some of which worked in partnership with academic health centers, were overshadowed by more aggressive health plans with limited interest in social mission (22).

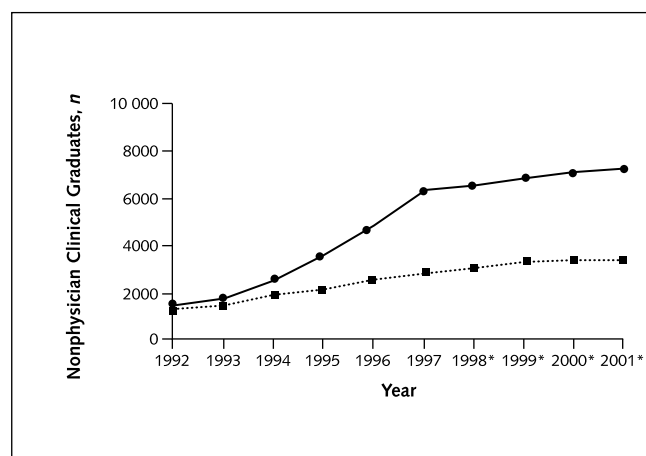
Finally, the 21st century began with some fundamental dynamics in place in the U.S. health care system: 1)

Figure 2. Mean annual physician net income (in real dollars) after expenses but before taxes from 1981 to 1998.



Data obtained from reference 9. Ob/Gyn = obstetrics/gynecology.

Figure 3. Number of nonphysician clinical graduates between 1992 and 2001.



The solid line represents nurse practitioners; the dotted line represents physician assistants. The asterisks represent projections. Data obtained from reference 11.

“Managed care” has not improved the cost, quality, and access issues as its advocates had envisioned; 2) health care costs are bound to escalate in years ahead, driven by demographic forces and new technologies; 3) the public has a powerful appetite for health care that shows no signs of abating; and 4) public policy is adrift, with no evident coherent strategy.

PRIMARY CARE CIRCA 2002: EXCESS SUPPLY MEETS TIERED DEMAND

The factors that we have described have combined with the unique dynamics among the health professions to create greater primary care supply than demand. The growth in the overall number of physicians has led the Council on Graduate Medical Education (COGME) and other policy bodies to the new view that no substantial shortage of primary care clinicians currently exists (23). For nonphysician primary care clinicians, the promise of prestige and access to reimbursement has resulted in dramatic growth in the supply of nurse practitioners and physician assistants providing primary care (10). Nurses in particular may find the troubled landscape of primary care a relative nirvana when compared with the problems facing “regular” hospital nursing practice. As a consequence, nursing leaders have emphasized attainment of advanced credentials and training to increase nursing’s prestige and scope (24). These nonphysician clinicians, in turn, are augmented by both a wide variety of other health professionals providing “alternative medicine” and by specialists delivering principal care to their patients with a single chronic condition.

Although most persons with private health insurance are in “loose” managed care arrangements, such as open-network HMOs and PPOs, these arrangements offer little prospect of reining in costs over the long haul. Indeed,

after several years of moderation in health care costs, both health insurance premiums and underlying costs increased at nearly double-digit rates in 2001 and 2002 (25). Most analysts believe that employees will gradually assume a greater burden of cost sharing over time and that, should the economy go into prolonged recession, employees will face far greater cost sharing and will have to pay a significant premium for the open access to wide networks that many currently enjoy (26, 27).

As a consequence, lower-income workers may increasingly “tier” into tightly managed HMOs, while higher-paid workers will prefer to pay for greater flexibility. Preliminary evidence suggests that this is already occurring. Gabel and colleagues found that workers in high-wage firms tend to enroll in PPOs and open-ended HMOs (which tend to cost more), while low-wage firms tend to offer traditional HMO coverage (which costs less) (28). Similarly, the percentage of Medicaid recipients in managed care has increased from 10% in 1991 to 56% in 2000 (29, 30). This tiering, predicted some time ago by Reinhardt (31), has become the common wisdom among health care futurists (32).

As the system tightens for middle- and low-income groups, however, the affluent (particularly, empowered aging baby boomers) will demand not only free choice of clinician but also the highest level of customer service. Already, some practices offer a “medical concierge” service in which physicians are only a cell phone call away 24/7; others offer “integrative” medical practices, which combine traditional western medicine with acupuncture, massage therapy, aromatherapy, and other adjunctive treatments.

In summary, the health insurance and patient markets for persons younger than 65 years of age will, in all likelihood, begin to “tier” into three tiers. The top tier will be the affluent, with full coverage or the ability to pay out of pocket. The middle tier will be the middle-class and upper-middle-class employee, with some choice but substantial cost sharing. The bottom tier will include low-income workers, Medicaid recipients, and the uninsured.

Medicare: Tiering’s “Wild Card”

Will Medicare tier like the private insurance market? Medicare managed care grew substantially in the mid-1990s, driven by consumer demand for coverage of prescription drugs. Recently, however, Medicare HMOs have begun to exit certain markets; enrollment in Medicare HMOs declined from a peak of 6.1 million enrollees in 1999 to 5.5 million enrollees as of December 2001 (33). To the extent that Medicare remains static, its nontiered, fee-for-service-oriented approach would provide a countervailing force against tiering.

It is unlikely, however, that Medicare will remain in its current form over the long haul. First, Medicare is being pressured to include prescription drug coverage and to cover the near-elderly uninsured. Second, both government and market-oriented policy experts believe that

Medicare requires revamping to move from a structure modeled on 1960s health insurance benefits and financing to one that supports introduction of practices to improve quality and control costs (34).

The most likely direction of future Medicare reform will be in the general direction outlined by the 1999 Bipartisan Commission on the Future of Medicare. The Commission, although it did not make an official recommendation to Congress, had a majority in favor of a “premium support” model, in which the government would pay a fixed, risk-adjusted premium to plans, thereby exposing consumers to the cost impact of their choice of plans and clinicians (35). The Commission’s views clearly indicate a consensus to, first, move Medicare toward greater use of competitive markets and, second, to create greater price sensitivity among consumers. Both of these forces, if actualized, would increase the likelihood of substantial tiering in our health care system.

Primary Care in a Tiered Marketplace

If the marketplace does evolve in this fashion, the function and approach of primary care could vary substantially by tier. In each tier, the epidemiology of disease and risk, the expectations of the clinician, and the supporting financial incentives and drivers will vary. These variations will begin to splinter primary care itself, both in terms of what is done and who does it. As this occurs, the very notion of “primary care” as a unified field of practice, applied in varying circumstances, faces the prospect of dissolution and being superseded by an orientation to economic niche.

Upper-Tier Primary Care: The Full-Service Broker

Just as the affluent engage the services of their accountants, stockbrokers, and personal trainers, they will also engage health professionals and expect the same level of service. Baby boomers will spend their earned and inherited wealth to bypass the usual hassles of medical care practice. They will expect to reach their physicians quickly by cell phone, fax, e-mail, or the Internet. They will expect their clinicians to offer customized syntheses of information and to arrange their visits to a preferred subspecialist. The “medical concierge” will grow as a niche, most likely as an adjunct service to high-end single or multispecialty groups. Clinicians will begin to offer comprehensive “wellness” programs using the models of current executive physical fitness programs and “lifestyle” programs, such as Canyon Ranch, a luxury spa that now offers medical services.

These clinicians will be continually thinking about how to enhance both service quality and revenues. One could envision attempts to brand these programs or develop franchises—consider the current value of the brand of internationally known wellness gurus Andrew Weil or Deepak Chopra. Most likely, high-end specialty practices will begin to add primary care, not because they believe in the basic concept but as a way to attract and retain pa-

tients—in marketing, this is known as a wrap-around, loss-leader service.

Middle-Tier Primary Care: Responsive Advocate or Diffident Bureaucrat?

This tier will most dramatically feel the tug between retaining classic concepts of professional autonomy and obligation to the patient versus accommodating the bureaucratic reality of contemporary medical practice. These strains can already be observed in large multispecialty groups and in prepaid group practices. Clinicians will want to provide high-quality comprehensive care, coordination, and continuity. On the other hand, they will also attempt to maintain their income and preferred work style, while continually struggling with demands placed on them by insurers, regulators, and patients. They will be asked by demanding patients to provide the same level of service as in the upper tier, without commensurate reimbursement. To adapt to these tensions, the more innovative will explore new team arrangements for care, group visits, or some forms of technology assistance. New services will spring up to help relieve some of the burden on these clinicians. For example, clinicians can now buy a practice newsletter off-the-shelf and add some customized information for their practice. Clinicians may “outsource” their e-mail and telephone queries from patients by using existing nurse triage services—essentially buying round-the-clock “customer support.” Physician Web site companies will offer a range of services, which will compete with vendors supplying electronic medical record systems and handheld prescription writing devices.

On the other hand, as physicians practice day-to-day and month-to-month—fighting with indifferent insurance companies and attempting to satisfy demanding patients—burnout and existential distress will be close to the surface for many physicians. Some will find renewal in new developments in their practice, such as technology enhancements, or in building communications skills. Others will become diffident bureaucrats, going through the motions but seeking satisfaction in family and outside interests. They will view medicine more as a job than a calling.

Lower-Tier Primary Care: The Community-Oriented Primary Care Advocate

As the second-tier physicians struggle to meet personal and professional goals, low-income patients will find access to care increasingly difficult. In most locales, low-income populations will become even more concentrated in safety-net hospitals and existing community health centers.

Primary care in these tiers will increasingly be thought of as a social mission. Physicians entering this tier will have no illusions concerning their income possibilities and will be attracted to the possibility of community-oriented primary care or a role as social advocate. Clinicians in this tier will become less connected to primary care and more aligned with advocacy movements for social justice. They will join Health Care for All, not the American College of

Physicians—American Society of Internal Medicine. Furthermore, these physicians will begin to bridge medicine and public health. As they work with vulnerable populations, they will readily observe the impact that community, social, and economic factors play in the health of their patients. They will work at the community level with public health advocates on issues of violence, substance abuse, lack of economic opportunity, and racism.

Clearly, these physicians will find the practice of primary care different from the practice of physicians in higher tiers. Their organizations will have far greater public than private financing, their personal incomes will be lower, and they may be happier. The teams needed to provide care in this tier will be broader in scope and function, including not only health professionals but also community health advocates, community organizers, and local community leaders.

Implications for Primary Care

As the marketplace evolves, practitioners will increasingly begin to align with their economic niche, not their specialty domain. For example, an upper-tier wellness practice will have more in common with an upper-tier cardiology group than with a lower-tier practice. Thus, whatever current solidarity exists within and among primary care disciplines will begin to erode over time. This process will be accelerated by the greater income stratification within primary care, with the greatest income growth naturally occurring in the upper tier. This emergence of a “class” distinction in primary care will further erode solidarity.

Each of the primary care disciplines will face unique challenges. The orientation of family medicine toward families and communities will lead it to populate the middle and lower tiers, although a few physicians will take their discipline’s holistic approach to the upper-tier “wellness” market. For general pediatrics, those in the upper-tier niche will need to develop novel ways to provide the level of service expected while developing a sustainable “business model” for practice. For example, upper-tier pediatricians may begin to bill for phone consultation but will also send nurses to the schools and soccer fields in affluent communities.

General internal medicine faces the most daunting challenges for the future. Although patients with complex, chronic illness will be concentrated in the middle and lower tiers, few internal medicine residencies have developed a training model for practice in either a bureaucratic organization or a low-income community. Some upper-tier internists will develop and market their acumen around complex areas of medical decision-making. Although the aging of the population will increase the population base for general internal medicine, general internists will be competing with specialists for these patients. Indeed, decreasing age-specific disability rates (36) suggest that “healthy aging” could be better for plastic surgeons than for internists. To survive and even thrive, general internists

in the middle and lower tiers will need to develop competencies and practice styles much closer to those of family medicine. Family medicine’s training model, which emphasizes family and community context and a biopsychosocial model of care, is more congruent with the practice realities of these tiers. Another niche for general internists will be the management of multiple, complex, chronic conditions—a practice that will blur the specialty boundary between general internal medicine and geriatrics.

Implications for the Future

If these predictions about the future organization and financing of health care come to pass, then clear implications for the immediate future exist. First, how managed care evolves will have a major impact on the future of primary care. If managed care returns to a tightly managed gatekeeping model and retains its bureaucratic, low customer service ethos, primary care will continue to be tarred by its brush. As a result, we can expect medical student interest in primary care to decrease to the 20% levels seen in the early 1990s. On the other hand, if managed care principles and practices evolve into “kinder and gentler” forms, either through consumer pressure, regulation, or changes in payment policy, the middle tier will look much more promising. Clinicians could see the opportunity to use advanced information technology to rationalize their practices and make better use of their time and energy.

Second, primary care policy should concern itself less with workforce issues and more with macrolevel organization and financing. A new consortium might begin analyzing how Medicare reform, Health Insurance Portability and Accountability Act (HIPAA) regulations, Patients’ Bill of Rights, or HMO lawsuits will affect primary care.

Five Challenges for Primary Care Clinicians

For all primary care clinicians, we see five major challenges in our forecast. First, current training in primary care does not provide the requisite skills for effective practice in any of the tiers we describe. Major training enhancements in communications skills, information technology, working in teams, disease prevention, and behavior change counseling will be needed (37).

Second, for primary care to survive as a construct in a new era, greater attention is needed for the essential “core values” of primary care. Perhaps primary care’s overarching focus should be on values and ethos, not solely on functions, because these functions will vary substantially in the future. Just as all of medicine has sought to unify the profession by focusing on core values of professionalism, primary care may need to do the same (21).

Third, this analysis suggests the need to consider primary care as a function that could be delivered by specialty physicians, not just the “generalist specialties.” Perhaps a new organization such as the “Society for Primary Care Practice,” open to any specialty, should be developed.

Fourth, general internal medicine and its relationship to primary care and to internal medicine require further

thought. Simply stated, the underlying conceptual basis of general internal medicine, wherein the parent discipline of internal medicine is applied to the primary care of adults, is not tracking with either the changing marketplace for medical care or with the evolution of internal medicine and the rise of the hospitalist movement.

Finally, like most ideas, primary care is a concept that must continue to have demonstrated utility—to the public, to the health professions, and to health care. The future segmentation of the market suggests that, unless fundamental changes in training, acculturation, and professional development of those who practice primary care occur, primary care as a concept will be swept away by economic, demographic, and social forces.

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